Appendix C: Participant Services

C-1: Summary of Services Covered (1 of 2)

a. Waiver Services Summary. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Service Type	Service	
Statutory Service	Adult Day Care	
Statutory Service	Case Management	
Statutory Service	Consumer Directed Attendant Care - Skilled	
Statutory Service	Prevocational Services	
Statutory Service	Respite	
Statutory Service	Supported Employment	
Extended State Plan Service	Specialized Medical Equipment	
Supports for Participant Direction	Financial Management Service - Supports the self-direction option	
Other Service	Behavioral Programming	
Other Service	Consumer Directed Attendant Care (CDAC) unskilled	
Other Service	Family Counseling and Training Services	
Other Service	Home and Vehicle Modification	
Other Service	Independent Support Broker - Consumer Choices Option	
Other Service	Interim Medicial Monitoring and Treatment (IMMT)	
Other Service	Personal Emergency Response System or Portable Locator System	
Other Service	Self Directed Community Support and Employment	
Other Service	Self Directed Goods and Services	
Other Service	Self Directed Personal Care - Consumer Choices Option	
Other Service	Supported Community Living	
Other Service	Transportation	

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Adult Day Health

Alternate Service Title (if any):

Adult Day Care

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04050 adult day health

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on regular or intermittent basis in a day care center. Meals provided as part of these services shall not

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult day services has an upper rate limit if there is no Veterans Administration contract. The upper rate limits are pulsihed in 441 IAC Chpater 79. The rates are subject to change on a yearly basis. A unit of service is 15 minutes, a half day (1 to 4 hours), a

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Adult Day Care

Provider Category:

Agency

Provider Type:

Adult Day Care Agencies that are certified by the Department of Inspections and Appeals

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agency that is certified by the Department of Inspection and Appeals as being in compliance with the standards for adult day services located at 481 Iowa Adminsiateive Code - Chapter 70.

Other Standard *(specify):*

The adult day service agency is responsible for ensuring that criminal background and abuse registry checks are conducted prior to direct service provision.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Deparmtent of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Case Management

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	Sub-Category 1:
01 Case Management	01010 case management
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Covered services. The following shall be included in the assistance that case managers provide to members in obtaining services:

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Payment for case management may not be made until the member is enrolled in the waiver. Payment can also only be made if case management activity is performed on behalf of the member during the month. Case Managers are required to have at least

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency - Provider
Agency	Agency - DHS
Agency	Agency- County

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency - Provider

Provider Qualifications

License *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

Certificate *(specify):*

Other Standard *(specify):*

“Qualified case managers and supervisors” means people who have the following qualifications:
1. A bachelor’s degree with 30 semester hours or equivalent quarter hours in a human services field (including, but

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services- Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency - DHS

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

Other Standard *(specify):*

Qualified case managers and supervisors” means people who have the following qualifications:
1. A bachelor’s degree with 30 semester hours or equivalent quarter hours in a human services field (including, but

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Case Management

Provider Category:

Agency

Provider Type:

Agency- County

Provider Qualifications

License *(specify):*

Certificate *(specify):*

An Agency that meets Iowa Administrative code 441.24 for case management services. The Agency submits their certification papers along with their provider application in order to be enrolled to provide case management

Other Standard *(specify):*

Qualified case managers and supervisors" means people who have the following qualifications:
1. A bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Providers are recertified every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Personal Care

Alternate Service Title (if any):

Consumer Directed Attendant Care - Skilled

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Skilled consumer-directed attendant care services shall be provided by the CDAC provider under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15 minutes provided by an individual or an agency.
Each service shall be billed in whole units.

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Health Agency
Agency	Assisted Living Program
Agency	Adult Day Service provider
Individual	Individual
Agency	Supported Community Living provider
Agency	Chore Provider
Agency	Community Action Agency
Agency	Home Care provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home Care Agency requriements are listed in 441 IAC Chpater 77.
Home health agencies are eligible to participate providing they are certified to participate in the Medicare program

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Assisted Living Program

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67

Other Standard *(specify):*

Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and evacuation

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Adult Day Service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

The Adult Day Care Provider standards are contained in the Department of Inspections and Appeals adminsitrative rules at 481 Iowa Adminsitrative Code Chapters 67 and 79.

Other Standard *(specify):*

Initial certification process for a nonaccredited program.
(1) Upon receipt of all completed documentation, including state fire marshal approval and structural and

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Deparmtent of Human Services, the Iowa Mediciad Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

CDAC Provider Qualifications are listed in 441 IAC Chapter 77

Other Standard *(specify):*

An individual who contracts with the consumer to provide attendant care service and who is:
(1) At least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human services, Iowa Medicaid Enterprise
For CCO employees, the Financial Management Service.

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Supported Community Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified under an HCBS waiver for supported community living listed in 441 IAC Chapter 77.

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Ioa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Chore Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.Providers must be:

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

“Community action agency” means a public agency or a private nonprofit agency which is authorized under its charter or bylaws to receive funds to administer community action programs and is designated by the governor to

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Departmet of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Consumer Directed Attendant Care - Skilled

Provider Category:

Agency

Provider Type:

Home Care provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of

Other Standard *(specify):*

The authorized agency shall ensure that each individual assigned to perform home care aide services meets one of the following:

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Prevocational Services

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:

04 Day Services

Sub-Category 1:

04010 prevocational services

Category 2: **Sub-Category 2:**

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member can develop non-job-task-specific strengths and skills that lead to paid employment in

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Exclusions. Prevocational services payment shall not be made for the following:
(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	CQL
Agency	CARF Accredited Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

CQL

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers accredited by the Council on Quality and Leadership

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Prevocational Services

Provider Category:

Agency

Provider Type:

CARF Accredited Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

79.39(22)
Providers of prevocational services must be accredited by one of the following:

Other Standard *(specify):*

Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Deparmtent of Human Services

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Respite

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1: 09 Caregiver Support

Sub-Category 1: 09012 respite, in-home

Category 2: 09 Caregiver Support

Sub-Category 2: 09011 respite, out-of-home

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite is to enable the member to

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The following limitations apply:
a.Services provided outside the member?s home shall not be reimbursable if the living unit where the respite is provided is

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Facility ICF/ID
Agency	Home Health
Agency	Facility - Hospital
Agency	Group Living Foster Care Facility
Agency	Facility - Residential Care Facility
Agency	Assisted Living Programs
Agency	Adult Day Care
Agency	Agency
Agency	Camps
Agency	Facility - Nursing Facility
Agency	Home Care Agency
Agency	Child Care Facility

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility ICF/ID

Provider Qualifications

License *(specify):*

Intermediate Care Facility for Persons with Intellectual Disabilities (ICF/ID) liscensed by the Department of Inspections and Appeals 481 IAC Chapters 63 and 64.

Certificate *(specify):*

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Health

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.9 (249A) Home Health Agency certified by Medicare

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility - Hospital

Provider Qualifications

License *(specify):*

Liscensed by the Department of Inspections and Appeals under 481 Chapter 51

Certificate *(specify):*

Other Standard *(specify):*

Enrolled as an Iowa Medicaid provider.
Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Group Living Foster Care Facility

Provider Qualifications

License *(specify):*

Group living foster care facilities for children licensed by the department according to 441?Chapters 112 and 114 to 116 and child care centers licensed according to IAC 441?Chapter 109.

Certificate *(specify):*

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Mediciad Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility - Residential Care Facility

Provider Qualifications

License *(specify):*

RCF liscensed by the Department of Inspections and Appeals under 481 IAC Chapter 57

Certificate *(specify):*

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Assisted Living Programs

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department of Inspections and Appeals UInder 481 IAC Chapter 67
Initial certification process for a nonaccredited program.

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Adult Day Care

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified by the Department of Inspections and Appeals as being in compliance with the standards for adult day services programs adopted by the departmentof elder affairs at 321 - Chapter 24.

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Mediciad Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies certified by the department to provide respite in a member's home that meet the organizational standards set forth in 441 IAC 77.39(1), 77.39(3)through 77.39(7)

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Camps

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Camps certified by the American Camping Association. The ACA-Accreditation Program:
• Educates camp owners and directors in the administration of key aspects of camp operation, program quality, and

Other Standard *(specify):*

Respite providers shall meet the following conditions:
Providers shall maintain the following information that shall be updated at least annually:

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Facility - Nursing Facility

Provider Qualifications

License *(specify):*

Liscensed by the Department of Inspections and Appeals 481 IAC Chpaters 58 and 61.

Certificate *(specify):*

Other Standard *(specify):*

Conditions of participation for nursing facilities. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Home Care Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care agencies that meet the Home Care requirements set forth in IAC 641-80.5(135), 641- 80.6 (1350 and 641-80.7 (135) or certified by Medicare as a Home Health agency

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Respite

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License *(specify):*

Child Care Facilities that are defined as child care centers, preschools, or child development homes registered pursuant to 441 IAC chapter 110.

Certificate *(specify):*

Other Standard *(specify):*

Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Statutory Service

Service:

Supported Employment

Alternate Service Title (if any):

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
03 Supported Employment	03010 job development
Category 2:	**Sub-Category 2:**
03 Supported Employment	03021 ongoing supported employment, individual
Category 3:	**Sub-Category 3:**
03 Supported Employment	03022 ongoing supported employment, group
Category 4:	**Sub-Category 4:**
03 Supported Employment	03030 career planning

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service for Individual Supported Employment is 15 minutes
A unit of service for Small Group Employment is 15 minutes

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	JCAHO
Agency	CQL
Agency	CARF
Agency	CAFC
Agency	ICCD

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

JCAHO

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services

Frequency of Verification:

Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:

Agency

Provider Type:

CQL

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities for similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
CARF

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Human Services

Frequency of Verification:
Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
CAFC

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An agency that is accredited by the Council on Accreditation of Services for Families and Children for similar services.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Human Services

Frequency of Verification:
Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Statutory Service
Service Name: Supported Employment

Provider Category:
Agency

Provider Type:
ICCD

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*
An agency that is accredited by the International Center for Clubhouse Development.

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Human Services

Frequency of Verification:
Every Four Years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Extended State Plan Service

Service Title:
Specialized Medical Equipment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14031 equipment and technology
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Specialized Medical Equipment shall include medically necessary items for personal use by the member with a brain injury which provide for the health and safety of the member which are not ordinarily covered by Medicaid, and are not funded by

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Members may receive specialized medical equipment once per month until a maximum yearly usage of $6,366.64 per year has been reached. The yearly usage dollar amount is subject to change on an annual basis. The upper rate limits are

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Retail and Wholesale businesses
Agency	Medical Equipment and Supply dealers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:

Agency

Provider Type:

Retail and Wholesale businesses

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Enrolled a providers in the Medicaid program. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Upon enrollment and every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Extended State Plan Service
Service Name: Specialized Medical Equipment

Provider Category:
Agency

Provider Type:
Medical Equipment and Supply dealers

Provider Qualifications

License *(specify):*

Certificate *(specify):*
441—77.10(249A) All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other

Other Standard *(specify):*
Enrolled as a provider in the Medicaid program

Verification of Provider Qualifications

Entity Responsible for Verification:
The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:
Upon enrollment and every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:
Supports for Participant Direction

The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.

Support for Participant Direction:
Financial Management Services

Alternate Service Title (if any):
Financial Management Service - Supports the self-direction option

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12010 financial management services in support of self-directio
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

The Financial Management Service (FMS) is necessary for all members choosing the self-direction option, and is available only

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A member who elects the consumer choices option may purchase the following services and supports, which shall be provided in the member's home or at an integrated community setting:

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Financial Management Service

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Supports for Participant Direction
Service Name: Financial Management Service - Supports the self-direction option

Provider Category:

Agency

Provider Type:

Financial Management Service

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The Financial Management Service must meet the criteria under 441 IAC Chapter 77.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Behavioral Programming

HCBS Taxonomy:

Category 1:

10 Other Mental Health and Behavioral Services

Sub-Category 1:

10040 behavior support

Category 2:

Sub-Category 2:

Category 3:

Sub-Category 3:

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Behavioral Programming consists of individually designed strategies to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors, which have interfered with the members ability to remain in the community.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is 15 minutes. There is an upper rate limit for this service which is subject to change on a yearly basis.

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Mental Health Center

Provider Category	Provider Type Title
Agency	Mental Health Service Provider
Agency	Home Health Aide Provider
Agency	Hospice Provider
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.
Agency	Brain Injury Waiver Providers

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Mental Health Center

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441?IAC Chapter 24

Other Standard *(specify):*

Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Mental Health Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441?Chapter 24, Divisions I and IV.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Home Health Aide Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

Other Standard *(specify):*

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprsie

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Hospice Provider

Provider Qualifications

License *(specify):*

Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481?Chapter 53

Certificate *(specify):*

Agencies which are certified to meet the standards under the Medicare program for hospice programs.

Other Standard *(specify):*

Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accreditation by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Behavioral Programming

Provider Category:

Agency

Provider Type:

Brain Injury Waiver Providers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers enrolled to deliver HCBS BI Waiver services in accordance with 441 IAC Chapter 77.39

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Consumer Directed Attendant Care (CDAC) unskilled

HCBS Taxonomy:

Category 1:	Sub-Category 1:
08 Home-Based Services	08030 personal care
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Consumer-directed attendant care may

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of services is 15 minutes. Services are billed in whole units. There are upper rate limits whcih are subject to change on a yearly basis.

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Home Care provider
Agency	Supported Community Living Provider
Agency	Chore provider
Agency	Assisted Living provider
Agency	Community Action Agency
Individual	Individual
Agency	Adult Day Care provider
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Home Care provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Home care providers that have a contract with the department of public health or have written certification from the department of public health stating they meet the home care standards and requirements set forth in department of

Other Standard *(specify):*

Standards
The authorized agency shall ensure that each individual assigned to perform home care aide services meets one of

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa DHS- Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Supported Community Living Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified under an HCBS waiver for supported community living.
Supported Community Living Provider requirements are listed in 441 IAC Chapter 77.

Other Standard *(specify):*

Supported Community Living Provider requirements are listed in 441 IAC Chapter 77.
Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Chore provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.33(7)Chore providers
a. Home health agencies certified under Medicare.

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Assisted Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Assisted living programs certified by the department of inspections and appeals 481 IAC Chapter 67
Initial certification process for a nonaccredited program.

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Community action agencies as designated in Iowa Code section 216A.93.
“Community action agency” means a public agency or a private nonprofit agency which is authorized under its

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

An individual who contracts with the consumer to provide attendant care service and who is:
(1) At least 18 years of age.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa DSH - Iowa Medicaid Enterprise
For CCO employees, the Financial Management Service.

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Adult Day Care provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Adult day care providers that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs adopted by the department of elder affairs at 321?Chapter 24

Other Standard *(specify):*

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Service Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Consumer Directed Attendant Care (CDAC) unskilled

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the sub rules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa DHS - Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Family Counseling and Training Services

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
10 Other Mental Health and Behavioral Services	10060 counseling
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Family counseling and training services are face-to-face mental health services provided to the member and the family with whom the member lives

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is one 15 minute increment. There is an upper rate limit that is subject to change on a yearly basis. Payment for group counseling is based on a group rate divded by six or the actual number of members participating in the group

Service Delivery Method *(check each that applies)*:

- [ ] **Participant-directed as specified in Appendix E**
- [x] **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- [ ] **Legally Responsible Person**
- [ ] **Relative**
- [ ] **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Hospice Provider
Agency	Home Health Aide
Agency	Community Mental Health Centers
Agency	Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider
Agency	Mental Health Service Provider
Individual	Qualified Brain Injury Professional

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Individual

Provider Type:

Hospice Provider

Provider Qualifications

License *(specify):*

Providers liscensed and meeting the hospice standards and requirements set forth in the Deprtment of Inspection and Appeals rules IAC 481- chapter 53

Certificate *(specify):*

Providers certified to meet the standards under Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441 83.81(249A)

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services , the Iowa medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Home Health Aide

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Home health aide providers certified by Medicare.

Verification of Provider Qualifications

Entity Responsible for Verification:

DHS, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Community Mental Health Centers

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers certified as Community Mental Health Centers established by the MH/DD commission set forth in 441 IAC Chpater 24, Divisions I and II, and that employ staff to provide family counseling and training who meet the

Other Standard *(specify):*

Providers for the services set forth in sub rules 24.4(9) through 24.4(13) shall meet the standards in sub rules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Agencies which are accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Accredited by a department-approved, nationally-recognized accreditation organization as a specialty brain injury rehabilitation service provider

Verification of Provider Qualifications

Entity Responsible for Verification:

The Department of Human Services, The Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Agency

Provider Type:

Mental Health Service Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers for the services set forth in subrules 24.4(9) through 24.4(13) shall meet the standards in subrules 24.4(1) through 24.4(8) in addition to the standards for the specific service. Providers of outpatient psychotherapy and

Other Standard *(specify):*

Mental health service provider" means an organization whose services are established to specifically address mental health services to individuals or the administration of facilities in which these services are provided. Organizations

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Family Counseling and Training Services

Provider Category:

Individual

Provider Type:

Qualified Brain Injury Professional

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Meet the definition of qualified brian injury professional as set forth in rule IAC 441- 83.81 (249A)

Other Standard *(specify):*

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Home and Vehicle Modification

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14020 home and/or vehicle accessibility adaptations
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

Service is included in approved waiver. There is no change in service specifications.

- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Covered home and vehicle modifications are those physical modifications to the member?s home or vehicle listed below that directly address the member?s medical or remedial need. Covered modifications must be necessary to provide for the health,

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

There is an annual limit established for this service which is subject to change on a yearly basis.
Only the following modifications are covered:

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency
Agency	Community Business
Agency	Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Providers meeting the requirements of 441 IAC Chapter 77.

Other Standard *(specify):*

Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Community Business

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

441 IAC 77.39(16)Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers?

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, the Iowa Mediciad Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Home and Vehicle Modification

Provider Category:

Agency

Provider Type:

Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Providers eligible to participate as home and vehicle modification providers under the elderly or ill and handicapped waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Independent Support Broker - Consumer Choices Option

HCBS Taxonomy:

Category 1:	Sub-Category 1:
12 Services Supporting Self-Direction	12020 information and assistance in support of self-direction
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Independent Support Brokerage service is necessary for all members who chose the self-direction option. This is a service that is included in the member's Budget. The Independent Support Brokerage will be chosen and hired by the member. The ISB will

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is necessary for members who choose the self-direction option at a maximum of 26 hours a year. When a member first initiates the self-direction option, the Independent Support Broker will be required to meet with the member at least monthly

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☐ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Individual Support Broker

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Independent Support Broker - Consumer Choices Option

Provider Category:

Individual

Provider Type:

Individual Support Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services- Iowa Medicaid Enterprise

Frequency of Verification:

Once initially trained, the Individual Support Broker is placed on a Independent Support Brokerage registry that is maintained at the Iowa Department of Human Services Iowa Medicaid Enterprise. The Independent Support Broker

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Interim Medicial Monitoring and Treatment (IMMT)

HCBS Taxonomy:

Category 1:	Sub-Category 1:
11 Other Health and Therapeutic Services	11010 health monitoring
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Interim medical monitoring and treatment services. Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A maximum of 48 15 min units are available per day. The is an upper rate limit for the service which is subject to change on a yearly basis.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Supported Community Living provider
Agency	Child Care Facility
Agency	Home Health Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Supported Community Living provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Human Services, Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Child Care Facility

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441?Chapter 110.

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Humans Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Interim Medicial Monitoring and Treatment (IMMT)

Provider Category:

Agency

Provider Type:

Home Health Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441—77.9(249A) Home Health agencies certified to participate in the Medicare program.

Other Standard *(specify):*

Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Humans Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Personal Emergency Response System or Portable Locator System

HCBS Taxonomy:

Category 1:	Sub-Category 1:
14 Equipment, Technology, and Modifications	14010 personal emergency response system (PERS)
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency. The necessary components of a system are:

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is a one time installation fee or month of service. Maximum units per state fiscal year shall be one initial installation and 12 months of service. The member's plan of care will address how the member's health care needs are met.

Service Delivery Method *(check each that applies)*:

- ☐ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☐ **Legally Responsible Person**
- ☐ **Relative**
- ☐ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Agency

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Personal Emergency Response System or Portable Locator System

Provider Category:

Agency

Provider Type:

Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Other Standard *(specify):*

The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Community Support and Employment

HCBS Taxonomy:

Category 1:	Sub-Category 1:
17 Other Services	17010 goods and services
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Limits
Community support and employment services must be identified on the individual budget plan. The individual budget limit will

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Community Support and Employment

Provider Category:

Individual

Provider Type:

Business

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual, Individual Support Broker and the Financial Management Service

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Community Support and Employment

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to successfully communicate with the member. Individuals and businesses providing services and

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every four years. The member retains the employer authority

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Goods and Services

HCBS Taxonomy:

Category 1:

17 Other Services

Sub-Category 1:

17010 goods and services

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Individual directed goods and services must be documented on the individual budget. The individual budget limit will be based on the service plan and the need for the services available to be converted. A utilization adjustment rate is applied to the

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Goods and Services

Provider Category:

Individual

Provider Type:

Business

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to

Verification of Provider Qualifications

Entity Responsible for Verification:

Individual, Individual Support broker, Financial Management Service

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Goods and Services

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 18 years of age. All persons must be able to demonstrate to the member the ability to perform the task or tasks hire to perform. All persons hired must have the availability to

Verification of Provider Qualifications

Entity Responsible for Verification:

The member, the independent support broker and the financial management service

Frequency of Verification:

Every four years. The member retains the employer authority

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Self Directed Personal Care - Consumer Choices Option

HCBS Taxonomy:

Category 1:

08 Home-Based Services

Sub-Category 1:

08030 personal care

Category 2:

Sub-Category 2:

Category 3: **Sub-Category 3:**

Category 4: **Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- **Service is included in approved waiver. There is no change in service specifications.**
- **Service is included in approved waiver. The service specifications have been modified.**
- **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Self-directed personal care services are services and/or goods that provide a range of assistance in the member's home or community that they would normally do themselves if they did not have a disability; activities of daily living and incidental

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Self-directed personal care services need to be identified on the individual budget plan. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports

Service Delivery Method *(check each that applies)*:

- **Participant-directed as specified in Appendix E**
- **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- **Legally Responsible Person**
- **Relative**
- **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Individual	Business
Individual	Individual

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Personal Care - Consumer Choices Option

Provider Category:

Individual

Provider Type:

Business

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services

Verification of Provider Qualifications

Entity Responsible for Verification:

The individual, Individual Support Broker and the Financial Management Service

Frequency of Verification:

Every Four Years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Self Directed Personal Care - Consumer Choices Option

Provider Category:

Individual

Provider Type:

Individual

Provider Qualifications

License *(specify):*

An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation. The type of license

Certificate *(specify):*

Other Standard *(specify):*

All persons providing these services must be at least 16 years of age. All persons must be able to demonstrate to the consumer the ability to successfully communicate with the consumer. Individuals and businesses providing services

Verification of Provider Qualifications

Entity Responsible for Verification:

The member and the Independent Support Broker and the Financial Management Service.

Frequency of Verification:

Every four years, the member retains the employer authority

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Supported Community Living

HCBS Taxonomy:

Category 1:

02 Round-the-Clock Services

Sub-Category 1:

02011 group living, residential habilitation

Category 2: 02 Round-the-Clock Services

Sub-Category 2: 02023 shared living, other

Category 3: 02 Round-the-Clock Services

Sub-Category 3: 02031 in-home residential habilitation

Category 4:

Sub-Category 4:

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Supported community living services are provided by the provider within the member's home and community, according to the individualized member need as identified in the service plan. Available components of the service are personal and home skills

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is:
(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for 8 or more hours per day

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Provider

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Supported Community Living

Provider Category:
Agency

Provider Type:
Provider

Provider Qualifications

License *(specify):*

Providers of services meeting the definition of foster care shall also be licensed according to applicable 441?Chapters 108, 112, 114, 115, and 116.

Certificate *(specify):*

Providers shall meet the outcome-based standards set forth in subrules IAC 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to

Other Standard *(specify):*

Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Service Specification

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Type:

Other Service

As provided in 42 CFR ?440.180(b)(9), the State requests the authority to provide the following additional service not specified in statute.

Service Title:

Transportation

HCBS Taxonomy:

Category 1:	**Sub-Category 1:**
15 Non-Medical Transportation	15010 non-medical transportation
Category 2:	**Sub-Category 2:**
Category 3:	**Sub-Category 3:**
Category 4:	**Sub-Category 4:**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one **:**

- ○ **Service is included in approved waiver. There is no change in service specifications.**
- ○ **Service is included in approved waiver. The service specifications have been modified.**
- ○ **Service is not included in the approved waiver.**

Service Definition *(Scope):*

Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. Whenever possible, family, neighbors, friends, or community agencies that

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

A unit of service is either per mile, per trip. Transportation may not be reimbursed simultaneously with any other transportation service and may not be duplicative of any transporation service provided under the State plan.

Service Delivery Method *(check each that applies)*:

- ☑ **Participant-directed as specified in Appendix E**
- ☑ **Provider managed**

Specify whether the service may be provided by *(check each that applies)***:**

- ☑ **Legally Responsible Person**
- ☑ **Relative**
- ☑ **Legal Guardian**

Provider Specifications:

Provider Category	Provider Type Title
Agency	Nursing Facilities
Agency	Area Agency on Aging
Agency	Regional Transit Agency
Agency	Non-Emergency Medical Transporation Provider contracted with the NEMT Broker
Agency	Community Action Agency
Agency	Transportation Provider
Agency	HCBS Provider Agencies

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Nursing Facilities

Provider Qualifications

License *(specify):*

Nursing facilities are licensed by the Department of Inspections and Appeals under 481 IAC Chapters 58, and 61.

Certificate *(specify):*

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Area Agency on Aging

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Area agencies on aging as designated in 17 IAC ?4.4(231):Any entity applying for designation as an area agency on aging must have the capacity to perform all functions of an area agency on aging as outlined in the Older Americans

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Regional Transit Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

As designated by the Iowa Department of Transportation in the Code of Iowa 28M.

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Non-Emergency Medical Transporation Provider contracted with the NEMT Broker

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441 IAC 77.39(18)

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Iowa Medicaid Enterprise, Provider Services contractor

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Community Action Agency

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Community action agencies as designated in Iowa Code section 216A.93.

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

Department of Humans Services Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

Transportation Provider

Provider Qualifications

License *(specify):*

Certificate *(specify):*

441-IA 77.39(18)

Other Standard *(specify):*

Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Department of Human Services, the Iowa medicaid Enterprise

Frequency of Verification:

Every four years.

Appendix C: Participant Services

C-1/C-3: Provider Specifications for Service

Service Type: Other Service
Service Name: Transportation

Provider Category:

Agency

Provider Type:

HCBS Provider Agencies

Provider Qualifications

License *(specify):*

Certificate *(specify):*

Certified or Accredited enrolled HCBS providers under441 IAC Chpater 24 and/ or Chapter 77

Other Standard *(specify):*

77.37(24) Transportation service providers. The following providers may provide transportation:
a. Accredited providers of home- and community-based services.

Verification of Provider Qualifications

Entity Responsible for Verification:

The Iowa Deparmtent of Human Services, the Iowa Medicaid Enterprise

Frequency of Verification:

Every four years

Appendix C: Participant Services

C-1: Summary of Services Covered (2 of 2)

b. Provision of Case Management Services to Waiver Participants. Indicate how case management is furnished to waiver participants (*select one*):

- **Not applicable** - Case management is not furnished as a distinct activity to waiver participants.
- **Applicable** - Case management is furnished as a distinct activity to waiver participants.
  Check each that applies:
  - **As a waiver service defined in Appendix C-3.** *Do not complete item C-1-c.*
  - **As a Medicaid state plan service under §1915(i) of the Act (HCBS as a State Plan Option).** *Complete item C-1-c.*

- [x] **As a Medicaid state plan service under §1915(g)(1) of the Act (Targeted Case Management).** *Complete item C-1-c.*
- [ ] **As an administrative activity.** *Complete item C-1-c.*
- [ ] **As a primary care case management system service under a concurrent managed care authority.** *Complete item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

FFS
Targeted case managers or integrated health home coordinators provide case management services to those fee-for-service participants

Appendix C: Participant Services

C-2: General Service Specifications (1 of 3)

a. Criminal History and/or Background Investigations. Specify the state's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services (select one):

- ○ **No. Criminal history and/or background investigations are not required.**
- ○ **Yes. Criminal history and/or background investigations are required.**

Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background

b. Abuse Registry Screening. Specify whether the state requires the screening of individuals who provide waiver services through a state-maintained abuse registry (select one):

- ○ **No. The state does not conduct abuse registry screening.**
- ○ **Yes. The state maintains an abuse registry and requires the screening of individuals through this registry.**

Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Pursuant to Iowa Code 135C. 33(5)(a)(1) and (5)(a)(3), prospective employees of all of the following, if the provider is regulated by the state or receives any state or federal funding must complete child abuse, dependent adult abuse and criminal background

Appendix C: Participant Services

C-2: General Service Specifications (2 of 3)

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one:*

- ○ **No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act.**
- ○ **Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).**

Appendix C: Participant Services

C-2: General Service Specifications (3 of 3)

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under state law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the state, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one*:

- **No. The state does not make payment to legally responsible individuals for furnishing personal care or similar services.**
- **Yes. The state makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services.**

Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) state policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the state ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the state policies specified here.*

A person who is legally responsible for a member may provide services to a waiver member.

- **Self-directed**
- **Agency-operated**

e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians. Specify state policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

- **The state does not make payment to relatives/legal guardians for furnishing waiver services.**
- **The state makes payment to relatives/legal guardians under specific circumstances and only when the relative/guardian is qualified to furnish services.**

Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-1/C-3 each waiver service for which payment may be made to relatives/legal guardians.*

A member's relative or legal guardian may provide services to a member. Payments may be made to any relative who is not the parent of a minor child, a spouse, or a legal representative of the member. Legal representative means a person, including an

- **Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-1/C-3.**

Specify the controls that are employed to ensure that payments are made only for services rendered.

- **Other policy.**

Specify:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Iowa Medicaid providers will be responsible for providing services to fee-for-service members. The Iowa Medicaid Provider Services Department markets provider enrollment for Iowa Medicaid. Potential providers may access an application on line through the website

Appendix C: Participant Services

Quality Improvement: Qualified Providers

As a distinct component of the State?s quality improvement strategy, provide information in the following fields to detail the State?s methods for discovery and remediation.

a. Methods for Discovery: Qualified Providers

The state demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

i. Sub-Assurances:

a. ***Sub-Assurance: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-a1: The IME will measure the number and percent of licensed or certification waiver provider enrollment applications verified against the appropriate licensing and/or certification entity. Numerator = # and percent of waiver providers verified against appropriate licensing and/or certification entity prior to providing services. Denominator = # of licensed or certified waiver providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Encounter data, claims data and enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted entity including MCO	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-Assurance: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-b1: The IME shall determine the number and percent of CDAC providers that met waiver requirements prior to direct service delivery. Numerator = # of CDAC providers who met waiver requirements prior to service delivery; Denominator = # of CDAC enrolled providers.

Data Source (Select one):
Other
If 'Other' is selected, specify:
Enrollment information out of ISIS. All MCO HCBS providers must be enrolled as verified by the IME PS.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contract entity	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

c. ***Sub-Assurance: The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.***

For each performance measure the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
QP-c1: The IME will measure the total number and percent of providers, specific by waiver, that meet training requirements as outlined in State regulations. Numerator = # of reviewed HCBS providers which did not have a corrective action plan issued related to training; Denominator = # of HCBS waiver providers that had a certification or periodic quality assurance review.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:
Provider's evidence of staff training and provider training policies. All certified and periodic reviews are conducted on a 5 year cycle; at the end of the cycle all providers are reviewed.

Responsible Party for data collection/generation*(check each that applies):*	**Frequency of data collection/generation***(check each that applies):*	**Sampling Approach***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☑ **100% Review**
☐ **Operating Agency**	☑ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☑ **Other** Specify: Contracted	☐ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:

	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Other** Specify:	☐ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The IME Provider Services unit is responsible for review of provider licensing, certification, background checks of relevant providers, and determining compliance with provider service and business requirements prior to initial enrollment and

b. Methods for Remediation/Fixing Individual Problems

i. Describe the State?s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

If it is discovered by Provider Services Unit during the review that the provider is not compliant in one of the enrollment and reenrollment state or federal provider requirements, the provider is required to correct deficiency prior to enrollment or

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☑ **State Medicaid Agency**	☐ **Weekly**
☐ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☑ **Other** Specify: contracted entity and MCO	☐ **Annually**
	☐ **Continuously and Ongoing**

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Other** Specify:

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Qualified Providers that are currently non-operational.

- ○ **No**
- ○ **Yes**

Please provide a detailed strategy for assuring Qualified Providers, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix C: Participant Services

C-3: Waiver Services Specifications

Section C-3 'Service Specifications' is incorporated into Section C-1 'Waiver Services.'

Appendix C: Participant Services

C-4: Additional Limits on Amount of Waiver Services

a. Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*select one*).

- ○ **Not applicable**- The state does not impose a limit on the amount of waiver services except as provided in Appendix C-3.
- ○ **Applicable** - The state imposes additional limits on the amount of waiver services.

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; (f) how participants are notified of the amount of the limit. (*check each that applies*)

- ☑ **Limit(s) on Set(s) of Services.** There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver.
  Furnish the information specified above.

  Total monthly cost of waiver, excluding case management and home and vehicle modifications may not exceed the amount allowed in 441 Iowa Administrative Code 83.82(2) d
- ☑ **Prospective Individual Budget Amount.** There is a limit on the maximum dollar amount of waiver services authorized for each specific participant.
  Furnish the information specified above.

  Total monthly cost of BI waiver services, excluding case management and home and vehicle modifications may not exceed the maximum amount allowed in 441 Iowa Administrative Code 83.82(2) d
- ☐ **Budget Limits by Level of Support.** Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services.
  Furnish the information specified above.
- ☐ **Other Type of Limit.** The state employs another type of limit.
  Describe the limit and furnish the information specified above.

Appendix C: Participant Services

C-5: Home and Community-Based Settings

Explain how residential and non-residential settings in this waiver comply with federal HCB Settings requirements at 42 CFR 441.301(c)(4)-(5) and associated CMS guidance. Include:

1. Description of the settings and how they meet federal HCB Settings requirements, at the time of submission and in the future.
2. Description of the means by which the state Medicaid agency ascertains that all waiver settings meet federal HCB Setting requirements, at the time of this submission and ongoing.

Note instructions at Module 1, Attachment #2, HCB Settings Waiver Transition Plan for description of settings that do not meet requirements at the time of submission. Do not duplicate that information here.

Detailed information and timelines for the HCBS Settings project are included in Attachment #2 HCB Settings.